Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BAYLOR SURGICAL HOSPITAL AT FORT WORTH
750 12TH AVENUE
FORT WORTH TX 76104

Carrier's Austin Representative Box
Box Number 01

Respondent Name
LIBERTY INSURANCE CORP

MFDR Date Received
April 9, 2012

MFDR Tracking Number
M4-12-2572-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per TDI Rule 134.403 the Requestor is entitled to reimbursement at a rate of 143% of the DRG. The Respondent underpaid the services provided and did not allow additional monies due after reconsideration."

Amount in Dispute: $4,468.87

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response for consideration to the dispute.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 14, 2011 To September 17, 2011	Inpatient Hospital Surgical Services	$4,468.87	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated December 20, 2011 (for dates of service September 14-17, 2011)
   - Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED. (Z652)
   - Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE. (Z710)
   - X133 – THIS CHARGE WAS NOT REFLECTED IN THE REPORT AS ONE OF THE PROCEDURES OR SERVICES PERFORMED. (X133)

   Explanation of benefits dated January 27, 2012 (for dates of service September 14-17, 2011)

- Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED. (Z652)
- Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE. (Z710)
- X133 – THIS CHARGE WAS NOT REFLECTED IN THE REPORT AS ONE OF THE PROCEDURES OR SERVICES PERFORMED. (X133)

Issues

1. Did the requestor file for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307(c)?
2. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. 28 Texas Administrative Code §133.307 (c) states:

   (2) Provider Request. The provider shall complete the required sections of the request in the form and manner prescribed by the Division. The provider shall file the request with the MDR Section by any mail service or personal delivery. The request shall include:

   (A) a copy of all medical bill(s), in a paper billing format using an appropriate DWC approved paper billing format, as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration in accordance with §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills);

   (B) a copy of each explanation of benefits (EOB), in a paper explanation of benefits format, relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB;

   (C) the form DWC-60 table listing the specific disputed health care and charges in the form and manner prescribed by the Division;

   (E) a copy of all applicable medical records specific to the dates of service in dispute.

   Review of the requestors submitted DWC060 the *Table of Disputed Services* lists the disputed dates of service September 14, 2011 through September 17, 2011. Review of the requestors submitted UB-04 lists dates of service September 7, 2011 through September 8, 2011. Review of the requestors submitted explanation of benefits dated December 20, 2011 and January 27, 2012 lists dates of service September 14, 2011 through September 16, 2011. Review of the requestors submitted operative reports lists date of procedure, September 7, 2011. The Division finds that the requestor did not file for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307(c).

2. Therefore, reimbursement is not recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 26, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.